

UNCLASSIFIED

Defense Technical Information Center Compilation Part Notice

ADP010931

TITLE: NATO Medical Support to Crisis Response Operations - A
Strategic View

DISTRIBUTION: Approved for public release, distribution unlimited

This paper is part of the following report:

TITLE: The Impact of NATO/Multinational Military Missions on Health
Care Management [l'Impact des missions OTAN/militaires internationales
sur la gestion des soins de sante]

To order the complete compilation report, use: ADA393199

The component part is provided here to allow users access to individually authored sections
of proceedings, annals, symposia, etc. However, the component should be considered within
the context of the overall compilation report and not as a stand-alone technical report.

The following component part numbers comprise the compilation report:
ADP010930 thru ADP010950

UNCLASSIFIED

NATO Medical Support to Crisis Response Operations - A Strategic View

Leo Klein, M.D., Ph.D.
 Brigadier General CZ Army
 ACE Medical Advisor
 Chief Medical Branch
 Logistics Division
 B-7010 SHAPE / Belgium

Martin Kasper, M.D., Ph.D.
 Lieutenant Colonel GE Air Force
 Deputy ACE Medical Advisor
 Chief Medical Branch
 Logistics Division
 B-7010 SHAPE / Belgium

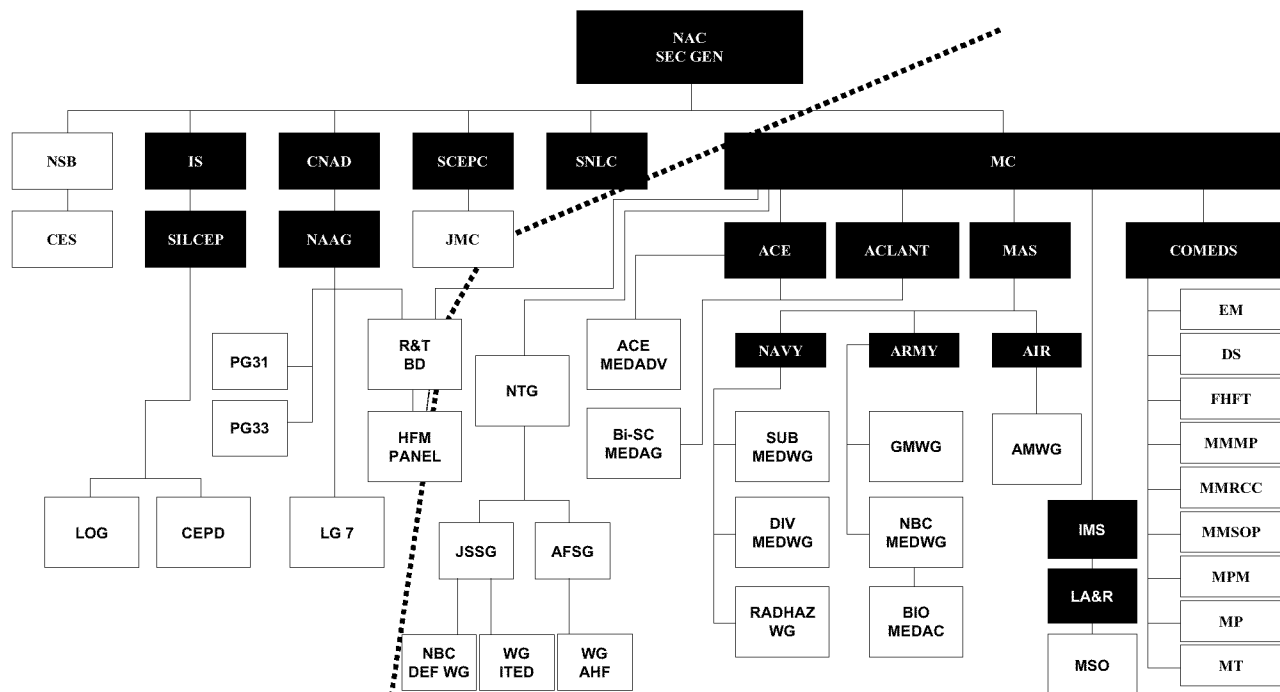
SUMMARY:

The paper will present the Strategic Command Europe's view on multinational medical operations including current developments and the way ahead.

DISCUSSION:

Medical Co-ordination in NATO

Medical Co-ordination in NATO is very complex. The purpose of the following diagram on medical co-ordination in NATO is definitely not to provide an overview of the principles, organisation and key bodies of NATO, but to give an idea of the complex and sometimes arcane ways in which they all affect medical planning in NATO.



The dotted red line divides the diagram into the civilian area of NATO on the left side of the slide and the military area on the right side. The organisational boxes in yellow represent NATO committees, working groups or sub-groups, which have or could have some direct medical activities, while those in blue do not; the latter are shown only for an overview of the organisation.

The bottom line of this picture is:

- Medical planning in NATO is complex and often confusing.
- There are many opportunities to participate in the process.
- However, most participation is on a national basis, and committee members are appointed by nations.

The NATO Nations' Surgeon Generals recently clearly stated their wish to modernise our medical services to peacetime standards. During the following minutes I will focus on the relationship of "medical" and "logistics" in NATO, the medical representation in the HQ architecture and responsibilities, the medical C2 structure in a joint environment, the medical support principles and policies and, I will provide an outlook.

Relationship of "Medical" and "Logistics" in NATO

We all know logistics has to ensure the movement and maintenance of forces, materiel readiness to include necessary infrastructure and services and also medical support. However, it is well understood that the medical support function has a unique non-transferable responsibility to maintain and recover the health of the fighting force. Officially, in NATO, medical and health support is part of logistics. In spite of that I would like to comment that this fact does no longer reflect the organisational structures of several member nations, where the medical service or staff is not part of logistics.

Health preserving and life saving measures have to comply with different basic rules than those applying to logistics:

- While a unit can be made logistically self sufficient for a planned number of days, it is not possible to make it medically self-sufficient.
- Indeed a complete and effective evacuation and treatment system needs to be available from the earliest stages of a deployment.
- The time frame in which a wounded patient must receive emergency surgical treatment is extremely limited.
- Every delay will lead to a higher morbidity or mortality.
- Medical personnel, materiel, and infrastructure are protected under the GENEVA conventions.
- Medical personnel therefore have non-combatant status. They must deploy their facilities away from targets of opportunity such as logistics installations, and as such cannot be members of local defensive forces.

Medical Representation in the HQ Architecture and Responsibilities

The provision of medical support is a command responsibility performed by the medical services. On behalf of the commander, the medical service must contribute to the achievement of the mission by conserving manpower. Since the main activity of medical and health support is humanitarian in nature, medical units are precious assets, which as well can be used for Crisis Response Operations (CRO). Humanitarian medical relief can make a positive psychological impact on public opinion at home, as well as in the disaster area itself. Finally, it is generally accepted that a perceived lack of medical support can significantly reduce the soldier's morale and will to fight.

The medical service performs this mission through the following roles and tasks:

First, the prevention measures are multiple and include:

- provision of advice and on health matters affecting operations;
- provision of appropriate immunisation and prophylactic measures for the area of operation;
- provision of health education and health promotion programs in the field of hygiene and sanitation;
- determination of medical fitness for operational personnel;
- determination and provision of NBC prophylactics.

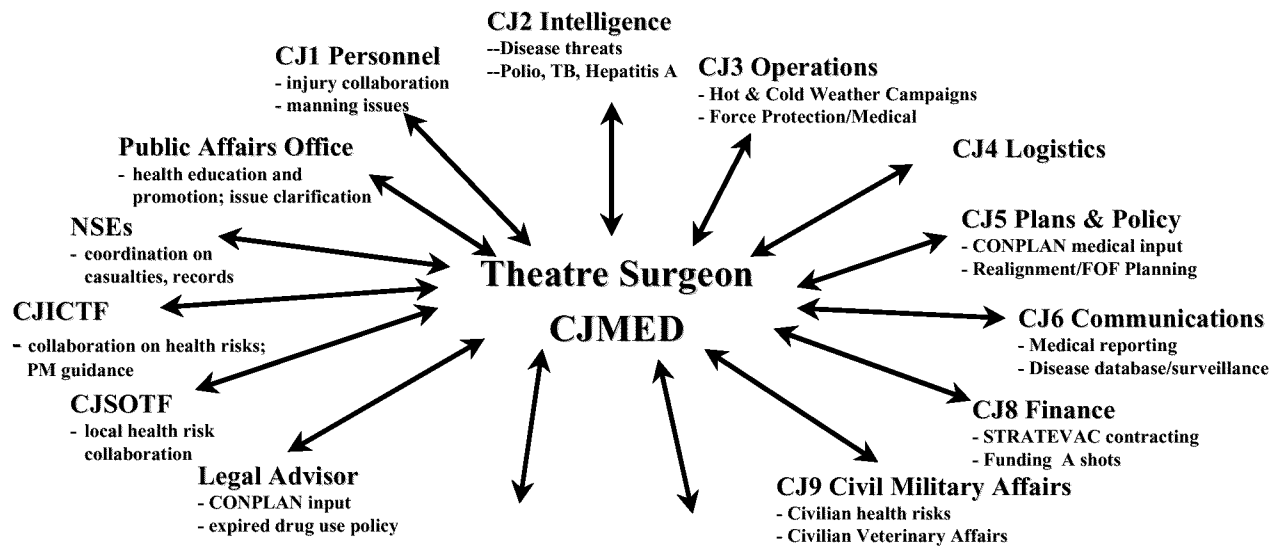
Second, evacuation encompasses the control and co-ordination of a casualty evacuation system, including aeromedical evacuation and medical regulating.

Third, treatment including promotion of first aid training; also provision of medical care and hospitalisation.

Fourth, the provision of medical logistics, which is actually the closest to a traditional logistics' function.

And finally, research and development aiming at providing the latest advances in prevention, diagnosis and treatment.

The following picture reflects the current situation in the well-developed and mature SFOR theatre. It might look very busy and complicated. What it actually depicts is the interface between all medical military matters and the rest of the military world.



The main interface medical has is with J4 Logistics. However, as you can see from this slide there are many other areas with which medical must co-ordinate and co-operate. The interface with Personnel is multifaceted and includes important subjects such as international law, patient regulating and tracking, and the maintenance of force strength through protection and preventive measures. Medical Intelligence plays an important and an increasing role in prevention and pre-emption of diseases in current and future operations. The intelligence community now fully recognises medical intelligence as a sub-set of intelligence as a whole. The medical planner, as an interface with operational staffs, has to be fully aware of current and future activities and this at an early stage. As a result, the medical support plans will be fully integrated in the overall operational plan. You are all aware of the fact that the estimates of battle casualties and DNBI are of particular interest for the commander, as they will predict the losses. It is also common knowledge that medical support will be a crucial part of the integrated mass casualty plans. Further, medical support to operations can not exist without an efficient and comprehensive medical communication system. It will range from operational communications links to high sophisticated information technology such as telemedicine. Civil military affairs (CIMIC) is another important area with which the medical organisation interfaces. NGOs, such as ICRC or "Medecins sans Frontieres", play an increasing role in humanitarian aid, which of course has medical implications. This represents a shift in the focus on military operations, which must be addressed through our doctrine and must be complemented by appropriate manpower resource. Last but not least important are the interfaces with legal advisors, engineers, national support elements (NSEs) and other staffs. In conclusion, medical military staffs operate in a highly specialised and multifaceted environment.

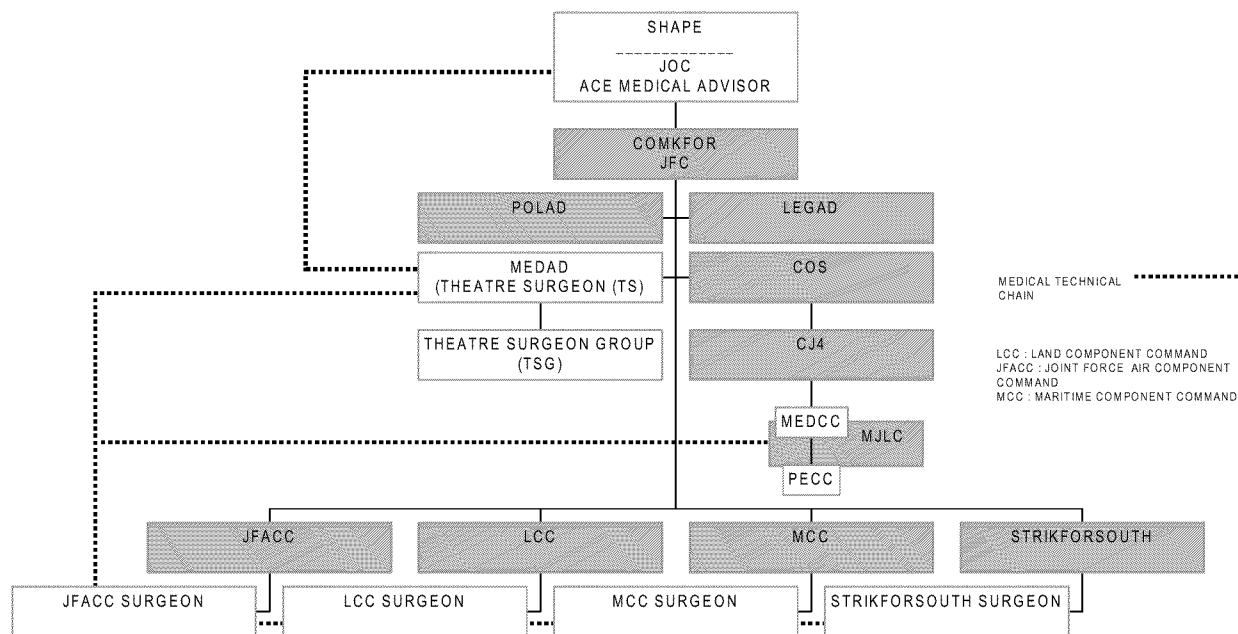
Medical C2 Structure in a Joint Environment

The medical C2 structure in a joint environment is based on the latest guidance provided by MC 326/1, AJP-4.10 and AJP-4.6. In principle, the technical medical chain extends from the SCs Medical Advisor through the Theatre Surgeons, to the Component Surgeons and all medical assets in the Theatre Area of Operations (TAOO). At every level, the Medical Advisor must have direct access to the commander. The Theatre Surgeons and the Component Surgeons will be located at their respective HQs.

During operations, the Medical Advisor of the HQ providing the HQ staff for the Combined Joint Task Force (CJTF) will normally serve as the Theatre Surgeon (TS). He is aligned at the advisory level in the CJTF HQs with an appropriate staff element, the Theatre Surgeon Group (TSG). He is also responsible for setting medical policy for the theatre, co-ordination of intra-theatre medical resources, and provision of joint medical guidance through liaison with multinational component command surgeons. The TS will co-ordinate all medical force-protection related actions (preventive medicine, medical intelligence, epidemiological and environmental survey, hygiene and sanitation, veterinary services). The TS will also

establish an overall MASCAL plan, in co-ordination with other HQ staffs and provide medical NBC advice. He directs the preparation and maintenance of a summary of the medical support capabilities in the theatre and other relevant medical information for theatre-wide dissemination like the theatre medical handbook for instance. Finally, he co-ordinates with and supports civil-military co-ordination (CIMIC) staffs in the area of public health and humanitarian assistance throughout the theatre. The staff of the TS expands through national augmentees from a nucleus to a full establishment, able to address the whole spectrum of medical issues.

While in the mature theatre of SFOR the Theatre Surgeon and Theatre Surgeon Group function have consequently evolved into specific CJMED posts, I show you here as an example, the medical command structure at a certain stage accepted by the nations during the KFOR and AFOR planning.



It illustrates how both, the Theatre Surgeon position and the Theatre Surgeon Group, are well positioned in order to ensure adequate medical control and co-ordinating capability. The MEDCC and its PECC remain under the MJLC and the J4, both as executive bodies of the theatre medical policy and its overall guidance.

On the other hand, the MEDCC is the executing body of the medical organisation for all CJTF operations. The aeromedical evacuation (AE) works under the technical direction of the TS and co-ordinates multinational joint and combined issues. As mentioned before, the MEDCC will normally be placed in the Multinational Joint Logistic Centre (MJLC).

When an MJLC is not formed, the MEDCC will be part of the J4 staff. The MEDCC is designed as a modular structure that encompasses two cells, the Medical OPS/Plans Cell and the Patient Evacuation Co-ordination Centre (PECC).

The main function of the MEDCC is the execution of medical plans and the implementation of medical policies set by the TS. It co-ordinates implementation and execution of the full spectrum of medical and health plans between all components of the CJTF. The function of the OPS/Plans Cell is to co-ordinate current medical operations and to develop medical support planning for future medical operations as directed by the MEDCC Chief. It develops and updates the theatre-level MASCAL plan and co-operates with the PECC in case of its execution. It provides the expertise required to implement the preventive medicine and environmental policies directed by the TS. The OPS/Plan Cell co-ordinates the activities of the “environmental health team”. During a CJTF mission there will generally be the need for qualified personnel to assess the health risk and to provide preventive and environmental medicine support. The PECC provides the theatre level medical evacuation and regulating functions for all patients, moving beyond formation boundaries, in conjunction with force components and theatre logistic and movement control agencies. It is responsible for patient tracking and the maintenance of the medical facility capability database. The PECC must have its own dedicated communication links to the key nodes of the evacuation system. Should a MASCAL situation arise, then the PECC will implement the TSs decisions and act as the interface between the TS and the units involved in the MASCAL.

Medical Support Principles and Policies

The next part of this paper will address some of the most significant “Medical Support Principles and Policies” for multinational medical operations. These principles and Policies are formulated in MC 326/1, which was approved in June 1999 by the Military Committee. AJP-4.10, the “Allied Joint Medical Support Doctrine”, will provide the respective doctrine based on MC 326/1. The ratification draft of AJP-4.10 has been forwarded to the nations in March 2000.

Standards of care: “Operational medical support to NATO forces should meet standards acceptable to all participating nations. Even in crisis or conflict, the aim is to provide a standard of medical care as close as possible to prevailing peacetime medical standards.” This support principle is a relatively new approach for the modern medical services and one of the main drivers for a certain number of medical requirements and force proposals for the year 2000. The achievement of this aim requires high standards of technical skill, equipment and medical supplies at the right time and in the right place.

Continuity of care: A patient passing through the military medical system from the point of wounding to the definitive care must be given continuous, relevant and progressive care. In-transit care must be provided during evacuation and the clinical condition of the individual is the key factor governing the timing and means of the patient’s evacuation. The principle of continuity of care refers essentially to two fundamental aspects of military medical support on the battlefield: the initial surgery and the evacuation.

The military surgical care system depends upon an organised pre-hospital treatment and medical evacuation system. It utilises somewhat differently and successively staged techniques to treat the injuries on the battlefield. Initial surgery, if necessary, renders the casualty transportable via rapid evacuation to a rear hospital for more intensive treatment. This means that several different surgeons in different medical facilities with different and generally increasing medical capabilities care for the individual who has been wounded in combat. This concept of casualty management allows forward medical facilities to be more mobile. It concentrates more resource-intensive casualty care far to the rear in secure areas where medical facilities are not required to move following changing tactical situations.

Fitness for evacuation: The clinical condition of the patient will govern the priority, timing, means and destination of evacuation. This is the reason why the co-ordination by medical regulating staff is required. And here we see the rationale for the role of the PECC (Patient Evacuation Co-ordination Centre) as part of the new CJTF-MJLC concept.

Time: Time is a critical factor in patient survival and recovery. Hence, time is the major driver dictating the type and location of medical assets. Timelines in providing emergency care and emergency surgery to the wounded is indeed crucial.

Future Developments and ongoing Challenges for the Medical Support in NATO

The overall idea for future developments is to stress the multinational approach in order to save costs and optimise capabilities. Lead nation approach and role specialist nation (RSN) arrangements can be the solution, if all participating nations agree. However, the Multinational Integrated Medical Support Unit (MIMU) Concept should not be excluded for the future. For the first time we are offering this possibility to the SFOR Follow on Forces (FOF) in order to take advantage of economies of scale. Indeed we encourage the establishment of medical facilities composed by different national modules. The nucleus and the command structure of the MIMU will be provided by a single nation, supplemented/augmented with capabilities, assets, services by other nations.

Within the Defence Capabilities Initiative (DCI) medical issues are addressed under the DCI Code SL 5b.

Taking into account the aim to create the bases of a responsive, coherent medical support structure at the level of a generic joint multinational Force, in which national force contingents and their incorporated national medical support elements can seamlessly be fitted in, the Committee of the Chiefs of Military Medical Services in NATO (COMEDS) recently approved the following medical sub-tasks in support of the DCI decision SL 5b:

- Nations and SCs should improve the quality of care and medical support.
- The general medical planning process must be improved.
- Medical force planning and generation must be improved.
- Current doctrine regarding Medical C2 must be implemented in all operations.
- Medical doctrine and procedures aiming at increasing multinational integration need to be further developed.

Subsequently COMEDS developed at its 2000 spring plenary meeting in Athens an action plan to continue the necessary work on DCI decision SL 5B. Beside several other requirements addressed to all COMEDS plenary members or COMEDS working groups, the following actions, which focus on multinational medical support, were formulated for the Strategic Commands (SC) to be the main action body with the assistance of the nations:

- Develop and publish the Multinational Medical Evaluation and Assessment Program (MMEA), which is the medical correlate of the Logistics Evaluation and Assessment Program (LEAP). It will provide a mechanism by which the medical support offered to an operation by NON-NATO Troop Contributing Nations can be evaluated for sufficiency, adequacy and quality.
- Develop a Medical Information Management System (MIMS), which can be used by all nations in a multinational operation and then begin the actual development of MIMS including integration with other information systems.
- Amend and broaden the ACE Medical Support Principles, Policies and Planning Parameters (AD 85-8) into as Bi-SC document for complete operational planning. AD 85-8, which is an excellent document for Article 5 medical planning, requires progression towards a tool being also usable for Crisis Response Operations (CRO).
- Write and publish a concept plan or functional planning guide for establishing a Multinational Integrated Medical Unit (MIMU). A well functioning MIMU exist today at SIPOVO in the SFOR theatre. MC 326/1 and AJP-4.10 authorises MIMUs as alternative mechanisms for the provision of health care in the field. There is a need for a compendium, which would provide a synopsis of lessons learned and guidance as to how to effectively establish a MIMU. It is the purpose of this seminar to discuss this and to provide assistance in this action. Develop and integrate the medical portion of the Host Nation Support (HNS) capabilities' catalogue. The SCs and the Senior NATO Logisticians Conference (SNLC) are currently developing this catalogue. It is necessary to ensure that the medical contributions, which may be available from each nation, are catalogued and made available for planning purposes.
- Ensure medical requirements are included in the respective Capability Packages (CP). These CPs are to provide infrastructure (e. g. Communication, vehicles) to the Multinational Joint Logistics Centre (MJLC). It is incumbent upon COMEDS to ensure that all medical requirements are included in these CPs.